BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: NATALI M., Claimant, and SOUTH CENTRAL LOS ANGELES REGIONAL CENTER, Service Agency.	OAH No. 2011050868

DECISION

Ralph B. Dash, Administrative Law Judge, Office of Administrative Hearings, heard this matter on August 8 and October 21, 2011, at Los Angeles, California.

Natalie M. (Claimant) was not present but was represented by her mother.

Johann Arias-Bhatia, Fair Hearing/Government Affairs Manager, represented South Central Los Angeles Regional Center (SCLARC, Regional Center, or Service Agency) on August 8, 2011; Beverly Morgan, Consultant, represented SCLARC on October 21, 2011.

ISSUE

Whether Claimant has a developmental disability, within the meaning of the Lanterman Act,[1] entitling her to Regional Center services.

COMBINED FACTUAL FINDINGS AND LEGAL CONCLUSIONS

1. Claimant was born on July 29, 2000. She applied to Regional Center for services based on a diagnosis of autism.

2. In order for Claimant to receive services under the Lanterman Act, not only must her condition fit into an eligibility category, it must also constitute a "substantial handicap" and

[1] Welfare and Institutions Code section 4500 et seq. Unless otherwise stated, all statutory references are to this code.

must not be solely from an excluded condition.

Code section 4512 defines "developmental disability" as:

> [A] disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

Under California Code of Regulations, title 17 (CCR), section 54000, the term "developmental disability" excludes those handicapping conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature.

These three exclusions from the definition of "developmental disability" under CCR section 54000 are further defined therein. Impaired intellectual or social functioning which originated as a result of a psychiatric disorder, if it was the individual's sole disorder, would not be considered a developmental disability. "Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have been seriously impaired as an integral manifestation of the disorder."

Nor would an individual be considered developmentally disabled whose only condition was a learning disability (a significant discrepancy between estimated cognitive potential and actual level of educational performance) which is not "the result of generalized mental retardation, educational or psycho-social deprivation, [or] psychiatric disorder . . . ." Also excluded are solely physical conditions such as faulty development, not associated with a neurological impairment, which results in a need for treatment similar to that required for mental retardation.

CCR section 54001 provides:

> (a) 'Substantial handicap' [as required to find a "developmental disability" under CCR §54000] means a condition which results in major impairment of cognitive and/or social functioning. Moreover, a substantial handicap represents a condition of sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential.[2]
>
> (b) Since an individual's cognitive and/or social functioning are many-faceted, the existence of a major impairment shall be determined through an assessment which

[2] For some reason, the phrase used in Welfare and Institutions Code §4512 is "substantial disability," not "substantial handicap," as used in the Regulations. There are no significant differences in the phrases.

shall address aspects of functioning including, but not limited to:

(1) Communication skills;
(2) Learning;
(3) Self-care;
(4) Mobility;
(5) Self-direction;
(6) Capacity for independent living;
(7) Economic self-sufficiency

In CCR section 54002, the term "cognitive" is defined as "the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience."

3. The Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision, 2000, American Psychiatric Association, also known as DSM-IV-TR) is a well respected and generally accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders. The manual uses a number system for the different disorders which is accepted by most medical and psychotherapeutic professionals (and insurance companies) as a shorthand method to designate the disorders that are more specifically described in the manual.

Beginning at page 75 of the DSM-IV-TR, the diagnostic criteria for Autistic Disorder are described as follows:

"A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

"(1) qualitative impairment in social interaction, as manifested by at least two of the following:

"(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

"(b) failure to develop peer relationships appropriate to developmental level

"(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

"(d) lack of social or emotional reciprocity

"(2) qualitative impairments in communication as manifested by at least one of the following:

"(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

"(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

"(c) stereotyped and repetitive use of language or idiosyncratic language

"(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

"(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

"(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

"(b) apparently inflexible adherence to specific, nonfunctional routines or rituals

"(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

"(d) persistent preoccupation with parts of objects

"B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

"C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder."

4. The disparate findings by the experts who examined Claimant, more fully discussed below, are most likely a function of the rather amorphous nature of Autistic Disorder. As referenced above, the diagnosis is made by a finding of six or more symptoms in three separate groups, with findings of two or more symptoms in the first group and findings of one or more symptoms in second and third groups. Once those criteria are met, the diagnostician must find delays or abnormal functioning in at least one of three additional areas, with onset prior to age three. The disorder must then be distinguished from Rett's Disorder or Childhood Disintegrative Disorder. With the diagnostic criteria being as broad

as they are, an individual's symptoms are subject to the diagnostician's discretion and interpretation to determine whether those symptoms satisfy the criteria. Further, because of the wide range of symptoms that can satisfy each of the criteria, individuals with Autistic Disorder can present with immensely disparate symptomatology. With such a broad presentation range, it is not difficult to understand how competent professionals can have widely differing views of whether a given patient's symptoms satisfy the criteria.

5. Portions of the discussion of Autistic Disorder in DSM-IV-TR shed light on autism's multifarious nature. Albeit lengthy, those portions warrant review to place the instant case in its proper perspective:

"**Diagnostic Features**

"The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as *early infantile autism, childhood autism,* or *Kenner's autism*.

"The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (e.g., eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and appropriate to developmental level (Criterion A1b) that may take different forms at different ages. Younger individuals may have little or no interest in establishing friendships. Older individuals may have an interest in friendship but lack understanding of the conventions of social interaction. There may be a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., not showing, bringing, or pointing out objects they find interesting) (Criterion A1c). Lack of social or emotional reciprocity may be present (e.g., not actively participating in simple social play or games, preferring solitary activities, or involving others in activities only as tools or 'mechanical' aids) (Criterion A1d). Often an individual's awareness of others is markedly impaired. Individuals with this disorder may be oblivious to other children (including siblings), may have no concept of the needs of others, or may not notice another person's distress.

"The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills. There may be delay in, or total lack of, the development of spoken language (Criterion A2a). In individuals who do speak, there may be marked impairment in the ability to initiate or sustain a conversation with others (Criterion A2b), or a stereotyped and repetitive use of language or idiosyncratic language (Criterion A2c). There may also be a lack of varied, spontaneous make-believe play or social imitative play appropriate

to developmental level (Criterion A2d). When speech does develop, the pitch, intonation, rate, rhythm, or stress may be abnormal (e.g., tone of voice may be monotonous or inappropriate to context or may contain questionlike rises at ends of statements). Grammatical structures are often immature and include stereotyped and repetitive use of language (e.g., repetition of words or phrases regardless of meaning; repeating jingles or commercials) or idiosyncratic language (e.g., language that has meaning only to those familiar with the individual's communication style). Language comprehension is often very delayed, and the individual may be unable to understand simple questions or directions. A disturbance in the pragmatic (social use) of language is often evidenced by an inability to integrate words with gestures or understand humor or nonliteral aspects of speech such as irony or implied meaning. Imaginative play is often absent or markedly impaired. These individuals also tend not to engage in the simple imitation games or routines of infancy or early childhood or do so only out of context or in a mechanical way.

"Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There may be an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus (Criterion A3a); an apparently inflexible adherence to specific, nonfunctional routines or rituals (Criterion A3b); stereotyped and repetitive motor mannerisms (Criterion A3c); or a persistent preoccupation with parts of objects (Criterion A3d). Individuals with Autistic Disorder display a markedly restricted range of interests and are often preoccupied with one narrow interest (e.g., dates, phone numbers, radio station call letters). They may line up an exact number of play things in the same manner over and over again or repetitively mimic the actions of a television actor. They may insist on sameness and show resistance to or distress over trivial changes (e.g., a younger child may have a catastrophic reaction to a minor change in the environment such as rearrangement of the furniture or use of a new set of utensils at the dinner table). There is often an interest in nonfunctional routines or rituals or an unreasonable insistence on following routines (e.g., taking exactly the same route to school every day). Stereotyped body movements include the hands (clapping, finger flicking) or whole body (rocking, dipping, and swaying). Abnormalities of posture (e.g., walking on tiptoe, odd hand movements and body postures) may be present. These individuals show a persistent preoccupation with parts of objects (buttons, parts of the body). There may also be a fascination with movement (e.g., the spinning wheels of toys, the opening and closing of doors, an electric fan or other rapidly revolving object). The person may be highly attached to some inanimate object (e.g., a piece of string or a rubber band).

"The disturbance must be manifest by delays or abnormal functioning in at least one (and often several) of the following areas prior to age 3 years: social interaction, language as used in social communication, or symbolic or

imaginative play (Criterion B). In most cases, there is no period of unequivocally normal development, although in perhaps 20% of cases parents report relatively normal development for 1 or 2 years. In such cases, parents may report that the child acquired a few words and lost these or seemed to stagnate developmentally.

"By definition, if there is a period of normal development, it cannot extend past age 3 years. The disturbance must not be better accounted for by Rett's Disorder or Childhood Disintegrative Disorder (Criterion C).

"Associated Features and Disorders

"Associated descriptive features and mental disorders. In most cases, there is an associated diagnosis of Mental Retardation, which can range from mild to profound. There may be abnormalities in the development of cognitive skills. The profile of cognitive skills is usually uneven, regardless of the general level of intelligence, with verbal skills typically weaker than nonverbal skills. Sometimes special skills are present (e.g., a 4½-year-old girl with Autistic Disorder may be able to 'decode' written materials with minimal understanding of the meaning of what is read [hyperlexia] or a 10-year-old boy may have prodigious abilities to calculate dates [calendar calculation]). Estimates of single-word (receptive or expressive) vocabulary are not always good estimates of language level (i.e., actual language skills may be at much lower levels).

"Individuals with Autistic Disorder may have a range of behavioral symptoms, including hyperactivity, short attention span, impulsivity, aggressiveness, self-injurious behaviors, and, particularly in young children, temper tantrums. There may be odd responses to sensory stimuli (e.g., a high threshold for pain, oversensitivity to sounds or being touched, exaggerated reactions to light or odors, fascination with certain stimuli). There may be abnormalities in eating (e.g., limiting diet to a few foods, Pica) or sleeping (e.g., recurrent awakening at night with rocking). Abnormalities of mood or affect (e.g., giggling or weeping for no apparent reason, an apparent absence of emotional reaction) may be present. There may be a lack of fear in response to real dangers, and excessive fearfulness in response to harmless objects. A variety of self-injurious behaviors may be present (e.g., head banging or finger, hand, or wrist biting). In adolescence or early adult life, individuals with Autistic Disorder who have the intellectual capacity for insight may become depressed in response to the realization of their serious impairment.

"Associated laboratory findings. When Autistic Disorder is associated with a general medical condition, laboratory findings consistent with the general medical condition will be observed. There are group differences in some

measures of serotonergic activity, but these are not diagnostic for Autistic Disorder. Imaging studies may be abnormal in some cases, but no specific pattern has been clearly identified. EEG abnormalities are common even in the absence of seizure disorders.

"Associated physical examination findings and general medical conditions. Various nonspecific neurological symptoms or signs may be noted (e.g., primitive reflexes, delayed development of hand dominance) in Autistic Disorder. The condition is sometimes observed in association with a neurological or other general medical condition (e.g., fragile X syndrome and tuberous sclerosis).

"Seizures may develop (particularly in adolescence) in as many as 25% of cases. Both microcephaly and macrocephaly are observed. When other general medical conditions are present, they should be noted on Axis III.

"Specific Age and Gender Features

"The nature of the impairment in social interaction may change over time in Autistic Disorder and may vary depending on the developmental level of the individual. In infants, there may be a failure to cuddle; an indifference or aversion to affection or physical contact; a lack of eye contact, facial responsiveness, or socially directed smiles; and a failure to respond to their parents' voices. As a result, parents may be concerned initially that the child is deaf. Young children with this disorder may treat adults as interchangeable, may cling mechanically to a specific person, or may use the parent's hand to obtain desired objects without ever making eye contact (as if it were the hand rather than the person that is relevant). Over the course of development, the child may become more willing to be passively engaged in social interaction and may even become more interested in social interaction. However, even in such instances, the child tends to treat other people in unusual ways (e.g., expecting other people to answer ritualized questions in specific ways, having little sense of other people's boundaries, and being inappropriately intrusive in social interaction). In older individuals, tasks involving long-term memory (e.g., train timetables, historical dates, chemical formulas, or recall of the exact words of songs heard years before) may be excellent, but the information tends to be repeated over and over again, regardless of the appropriateness of the information to the social context. Rates of the disorder are four to five times higher in males than in females. Females with the disorder are more likely, however, to exhibit more severe Mental Retardation."
(DSM-IV-TR, pp. 70-73.) (Bold and italic print in text.)

6. Claimant is now 11 years old. She is very attached to her mother, calling her mother her "best friend." Indeed, Claimant's mother spends hours every day coaching, cajoling, teaching and watching her daughter. She noted that Claimant has many deficits in her

activities of daily living. Claimant will not shower or brush her teeth without prompts. Although Claimant can dress herself, she cannot select her own clothing or dress appropriately for the weather or social conditions. Claimant can tell time with a digital but not analog clock or watch. Claimant has difficulty in making simple purchases as she does not count change, although she has the ability to do so. Claimant cannot take public transportation on her own; her mother has attempted to teach her how to do it but has been unsuccessful. Claimant can do small chores around the house but rarely completes any task without prompts. She does not know how to wash dishes. Claimant does not know how to cross the street safely. She will walk into traffic if not restrained. Claimant can make a bowl of cereal but cannot make a sandwich for herself. While she can use a microwave oven, she is unable to get food or put it on a plate for cooking.

7. Claimant's greatest deficits appear to be in social skills. She soothes herself by self-stimulation. She will do this at home, in any part of the house, regardless of who else may be present. She may also do this in other places, such as in her grandmother's house or the office of one of the psychologists who examined her. Claimant has no friends and no interest in making friends. Although her mother has taken the time to introduce Claimant to neighborhood children, Claimant stated she "is not ready" to play with them. Claimant does not engage in imaginative or imitative play. She tantrums often so her mother is unable to take her to the shopping mall. Claimant has other autistic-like behaviors which are described in Finding 15 below. These behaviors manifested themselves before Claimant was three years old.

8. Claimant was assessed twice by Regional Center psychologists, each of whom relied in great part on testing they administered. However, the test scores each achieved were so dissimilar it appeared as if the examiners were working with different children. Ann L. Walker, Ph.D, examined Claimant on February 20, 2008. Dr. Walker administered a number of tests, including the Leiter International Performance Scale-Revised (Leiter-R), the Wide Range Achievement Test-4th Revision (WRAT 4), the Autism Diagnostic Observational Schedule, Model III (ADOS Module III) and the Vineland Adaptive Behavior Scales 2nd Edition (Vineland II).

9. From the test results on the Leiter R, Dr. Walker concluded Claimant had a full scale IQ of 121 showing that Claimant's "cognitive intellectual skills were in the significantly above average or gifted range" with significantly above average abstract reasoning abilities. Despite this high intelligence (at least according to Dr. Walker's testing), Claimant's "word reading and spelling skills were at a kindergarten level [although Claimant was in the second grade]." Dr. Walker attributed this discrepancy between intelligence and academic achievement to Claimant's having been instructed in Spanish while in kindergarten and first grade, switching to English in the second grade. Subsequent testing done by Claimant's school district in October 2010, using the more comprehensive Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV) showed Claimant's full scale IQ to be 80, more than one standard deviation below the norm, meaning Claimant has, at best, low average intellectual functioning.

10. The VABS-II measures the personal and social skills of individuals. Adaptive behavior refers to the individual's typical performance of day-to-day activities. These scales

assess what a person actually does, as opposed to what he or she is capable of doing. VABS-II covers adaptive behaviors in four different domains: communication, daily living skills, socialization and motor skills.[3] It also provides for a composite score that summarizes the individual's performance across all of these domains. Information for the VABS-II is typically gleaned from the person who best knows the subject. In this case, that would be Claimant's mother; however, in her report (Exhibit 7), Dr. Walker did not indicate who provided the information. The norm is 100 with standard deviations of 15. More than two standard deviations below the norm indicate significant impairment. Dr. Walker concluded that Claimant's Adaptive Behavior Composite was 85, placing her in the low average range. However, subsequent testing done by Regional Center psychologist Roberto De Candia, Ph.D., on March 16, 2011 (Exhibit 5), showed Claimant's VABS-II composite to be 60, more than two standard deviations below the norm, placing Claimant in the "mild adaptive deficit range."

11. Dr. Walker and Dr. De Candia each interviewed Claimant one time before writing their respective reports. Dr. Walker had no diagnosis for Claimant. Dr. De Candia diagnosed Claimant as having "Mixed Receptive/Expressive Language Disorder (by history)/Evaluate for the presence of ADHD, combined type." At the hearing of this matter, Staff Psychologist Sandra Watson, Psy.D., testified on behalf of Regional Center. Dr. Watson never interviewed or tested Claimant. Her testimony was based solely on a review of records.[4] Dr. Watson concluded that, based in large part on the results of the ADOS Module-III, Claimant did not have Autism. Dr. Watson referred to the ADOS as the "gold standard" for evaluating diagnosing Autism, and Claimant's scores (zero in every domain except one, with a cut-off of 10 for diagnosis of Autism) made it unlikely Claimant has Autism.

12. Psychologist Paul Mancillas, Ph.D., evaluated Claimant, prepared a report (Exhibit 8) and testified on Claimant's behalf. Dr. Mancillas met with Claimant five times before preparing his March 7, 2011 report. His report is exceptionally thorough and his testimony was consistent with his report. Over the course of the five visits, Dr. Mancillas administered 18 different tests. He did not consider the results of the ADOS Module III administered by Dr. Walker as being definitive on the diagnosis of Autism. In fact, he testified that the term "gold standard" was coined by the test's publishers and was not a substitute for a thorough evaluation which includes multiple observations, not one. The ADOS does not test for "executive function of the brain."

13. A number of the tests Dr. Mancillas administered were aimed at measuring Claimant's executive function, which he opined was crucial to determining whether an individual has Autism. He defined executive functioning as a person's everyday ability to function and adapt to new and different stimuli. According to the United States National Institutes of Health, executive function of the brain controls "activities like thinking, organizing,

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[3] Claimant's motor skills are not an issue in this matter.

[4] Because Dr. Watson did not personally test and interview Claimant, her testimony is given less weight than the evidence presented by other experts who had tested/interviewed Claimant. (See *People v. Bassett* (1968) 69 Cal.2d 122, 141.)

planning, and problem solving." (http://www.nia.nih.gov.) Neither Dr. Walker nor Dr. De Candia tested Claimant's executive functioning.

14. According to Dr. Mancillas, Claimant has a very difficult time with frustration because she does not have the ability to adapt to new situations. She also has "low emotional control." Claimant's greatest deficit is her inability to have "reciprocal interactions" with others--she has virtually no social skills, which is highly suggestive of autism. Dr. Mancillas observed Claimant's self stimulation in addition to observing her perform other self-soothing behaviors such as humming, singing and rocking. Dr. Mancillas also opined that Claimant has an anxiety disorder which is commonly found in those with Autism.

15. In detailing the basis for his determination that Claimant is autistic, Dr. Mancillas wrote the following in his report:

> Many [of Claimant's] teachers have reported autistic-like behaviors at school. She is not social and she is very quiet and withdrawn. She can become upset when routine is changed and does have difficulty with peers. Her 3rd grade teacher strongly indicated that she believes she has autistic features. There are some fixations and obsessions, as well as compulsive behaviors that were presented around that time. The parents identified that she has many problems with learning and organizing activities. She does not benefit from experience and has much difficulty with transitions. She is unable to complete activities in a reasonable period of time. She does not understand time constraints and can become quickly frustrated and will give up easily. At times, she speaks in a monotone voice and will have difficulty understanding what others are saying. She needs more time than other children to complete her schoolwork. She has confusion with direction and orientation. With regard to attention, her mind appears to go blank at times and she has difficulty paying attention in class, at home, and with other children. She frequently forgets school assignments and what she has been told recently. With regard to behaviors, she can be extremely emotional, fearful, and nervous. She is impulsive and disinhibited and often appears to be depressed. She is quite dependent for her age and does engage in unusual behaviors. Her self-esteem is very low. She does engage in self-stimulation and has exhibited inappropriate sexual behavior. Social skills are very poor and she seems to be uninterested in other people. She is inclined to withdraw and to play by herself. Her behavior is very different depending on the situation she is in. She meets most if not all of the criteria for ADHD, Combined Type. She is inattentive, impulsive, and hyperactive. The parents also were asked to complete the behavior checklist and they identified numerous problems. They describe her as being argumentative and failing to finish things that she starts. She also tends to be extremely dependent and will frequently complain of loneliness. She experiences fears that she might do something bad. She feels the need to be perfect and at the same time might feel worthless or inferior. She can be impulsive and acts without thinking. She will overeat and is notably overweight. She shows a preference to being with younger kids. She is

self-conscious and easily embarrassed. She is also inattentive and easily distracted. She exhibits sudden changes in mood or feeling. She has fixations on certain toys, movies, and books. She will ignore others when they are greeting her and she will act like she does not see them.

The parent and the teacher were asked to complete ADD Scales to provide additional information regarding the question of ADHD. There is no doubt that she did exhibit ADHD signs and symptoms during the testing sessions. The teacher responded to her form indicating that there are definitely severe levels of ADHD based on poor organization, an inability to focus, inconsistent effort inconsistent memory functioning, and some hyperactivity. The strongest concern is related to her inability to control her emotions. She views her as often losing focus and becoming easily overwhelmed by tasks that are very manageable. She seems to be excessively sensitive to criticism from others. She often appears to be daydreaming and preoccupied with her own thoughts. The parents also completed this form and they also concluded very severe levels of ADHD. They also perceive problems in all areas that were previously mentioned, but they also indicate that hyperactivity is much more evident at home than in the classroom situation. She appears to get overly anxious when she is not able to remember things previously known. She tends to be slow to react or to get started. She gives up too easily when trying to learn. She can get easily irritated and has sudden outbursts of temper. Effort fades quickly on tasks that are overwhelming to her. The Behavior Rating Inventory of Executive Functioning was also completed by the parents and they do indicate some moderate problems with regard to executive skills specifically related to [Claimant's] difficulty with initiating, as well as planning and organizing. They also indicate difficulty with shifting behavior during times of transition, as well as inhibiting other types of behavior. Overall, they consider that her problems with executive skills in areas of cognition and behavior to be at moderate levels of impairment.

The issue of Autism is extremely important. It was believed that this question was not adequately answered during an evaluation, which consisted of one session, which assessed non-verbal intelligence and over emphasized results from the Autism Diagnostic Observational Schedule. Very few questions were asked regarding her social skills other than with the Autism Diagnostic Interview. The parents each completed their own forms assessing social responsiveness. The father concluded that there are significant social deficits in areas of social cognition, social communication, social motivation, and social awareness. He also identified that there are many mannerisms which are quite autistic. She scores in the range which would conclude a clinical diagnosis of an Autistic Disorder. He does indicate that she will tend to concentrate too much on parts of things rather than seeing the whole picture. She does get teased a lot in social situations and has an unusually narrow range of interests. The mother completed her form and she also concluded severe levels of social dysfunction. She also identifies problems in the various areas mentioned above and also

indicated autistic mannerisms. She indicates that when [Claimant] is under stress, she will show rigid or inflexible patterns of behavior that seem very odd. She gets frustrated when trying to get ideas across in conversations. She does not join group activities unless told to do so. She seems to have overly serious facial expressions, which does not endear her to others. She does not pick up on certain social cues and seems to have difficulty related to adults and some of her peers. The mother, father, and teachers completed the Autism Rating Scale. All four concluded that there are significant problems with social interaction. The mother responded to her form with the rating suggesting that Autism is very likely. This is primarily due to poor social interaction. Other areas are not as strong with regard to autistic features as she may not often exhibit stereotyped behaviors or problems with communication. It is recognized that she avoids establishing eye contact and will make unusually high pitched sounds for the purpose of self-stimulation. The father concluded that there is a possibility of Autism and he does not perceive that she has problems with stereotyped behaviors. He recognizes some problems with communication and social interaction. Her Math and P. E. teacher suggests that it is very likely that she has Autism and that she is inclined to struggle with social interaction and certain aspects of communication She often behaves in an unreasonably fearful or frightened manner. She can become very upset when routines are changed. Her general education teacher indicated that it is very likely that she has Autism based on poor communication and deficiencies in social interaction. She often looks away when others are talking to her and has been observed to be staring at her hands, objects, or items in her environment for long periods of time. She does certain things repetitively and will become upset when routines are changed. A final assessment has the mother complete the Syndrome Questionnaire. This asks questions about various autistic-like traits and the responses do support a diagnosis of Autism based on [Claimant's] difficulty with other children and a lack of interest in participating in competitive games and activities.

A final assessment allowed for [Claimant] to describe herself. She responded to a brief anxiety inventory indicating that she often experiences anxiety in social situations. She often fears that other people will tease her and that she often will think about scary things. She is afraid that she will get hurt and she has problems with sleeping. A projective drawing does suggest a considerable amount of anxiousness, but also an inclination toward introversive types of behavior. She may feel immobile in social situations and feels somewhat distant from others. She is cautious and careful around others and may not completely trust relationships because of her fear of being ridiculed. She has an unusual way of perceiving social interactions and she tends to lean toward the extreme in conflict. She tends to have magical solutions to problems. She struggles with her obligations and responsibilities to learning in the academic environment. She is unable to effectively communicate her struggles, but it is certain that she probably struggles on those tasks which involve time limitations. She does indicate that she will struggle with appropriate management of her emotions.

SUMMARY OF THE FINDINGS

> Neuropsychological testing was requested in order to rule out an Autistic Disorder. There is much evidence from teachers, mother, and father who consistently conclude that she exhibits autistic features in various environments. Social dysfunction is especially noted as she will also exhibit autistic-like mannerisms in social situations with also exhibiting deficiencies in social communication and social awareness. She clearly does not understand the unwritten rules of social play and does have a history of stereotyped behaviors, and continues to exhibit some stereotyped behaviors. . . . Overall, I would conclude that Claimant has an Autistic Disorder based on deficient social functioning, difficulty with effective communication in many situations, and old fragments of stereotyped behaviors which are notably hidden in the social arena. With increase in the exposure to stressful situations, the autistic symptoms will become more apparent. Thus, I would conclude that she has a high functioning type of Autism. In addition, I would conclude a co-existing condition of ADHD, Combined Type. I would also suggest further and more detailed assessment in the area of reading as there are signs and symptoms of at least mild levels of Dyslexia.

16. In applying all of the foregoing documented behaviors of Claimant to the DSM-IV TR criteria set forth in Finding 3, it is evident Claimant exhibits the symptoms of Autism and Dr. Mancillas' diagnosis that Claimant has Autism is correct. Claimant has "significant impairment in social interaction" by her failure to develop peer relationships (criterion A(1)(b)), her lack of spontaneous seeking to share interests with other people (criterion A(1)(c)), and her lack of social reciprocity (criterion A(1)(d)); she has "qualitative impairments in communication" by her inability to initiate or sustain a conversation with others (criterion A(2)(b)) and her lack of varied spontaneous social imitative play (criterion A(2)(d)); she has "restricted repetitive and stereotyped patterns of behavior" as shown by her rocking, humming and self-stimulation (criterion A(3)(c)). These impairments include abnormal social interaction (criterion B). Having examined Claimant, none of the three psychologists has suggested Claimant's "disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder" (criterion C).

17. However, as set forth in CCR section 54001, subdivision (b), because an individual's cognitive and/or social functioning are many-faceted, there are at least seven categories relative to "adaptive functioning" that must be examined as well. These categories are the same or similar to the categories of adaptive functioning skills listed in the DSM-IV TR that, to support a diagnosis of mental retardation, requires a finding of significant limitations in at least two such skills. Applying the evidence to the seven listed categories reveals the following:

(1) Communication skills: Claimant's communication skills problems, by

themselves, are neither severe enough nor sufficiently impairing to constitute a developmental disability.

(2) Learning: The evidence shows Claimant is significantly impaired in her ability to learn.

(3) Self-care: Claimant's ability to take care of herself is impaired. She regularly fails to complete her activities of daily living without many prompts and supervision.

(4) Mobility: Claimant's mobility is impaired; she cannot cross the street by herself nor can she take the bus.

(5) Self-direction: Claimant has little self-direction. She needs prompts in virtually all aspects of her daily life.

(6) Capacity for independent living: Not applicable as Claimant is a minor.

(7) Economic self-sufficiency: Not applicable as Claimant is a minor.

18. Based on all of the foregoing, it is found that Claimant has established by a preponderance of the evidence that she has a "substantial handicap" within the meaning of CCR section 54001. Accordingly, Claimant is entitled to regional center services under the Lanterman Act.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

South Central Los Angeles Regional Center shall accept Claimant as a client.

DATED:_____

_____
RALPH B. DASH
Administrative Law Judge
Office of Administrative Hearings

Notice: This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.